MEDI-CAL UPDATE Part 2
Billing and Policy
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Allied Health • Psychological Services

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Contents

2005 CPT-4/HCPCS Updates: Implementation November 1, 2005

The 2005 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2005. The affected codes are listed below. Only those codes representing current or future Medi-Cal benefits are included. Please refer to the 2005 CPT-4 and HCPCS Level II code books for complete descriptions of these codes. Specific policy, billing information and manual replacement pages reflecting these changes will be released in a future *Medi-Cal Update.*

CPT-4 Code Additions

Acupuncture
97810, 97811, 97813, 97814

HCPCS Level II Code Additions

Durable Medical Equipment
A7045, E0849, E1039, E1229, E1239, E2205, E2206, E2291 – E2294, E2368 – E2370, E2601 – E2621, E8000 – E8002

Orthotic Procedures
L1932, L2005, L2232, L4002

Prosthetic Procedures
L5685, L5856, L5857, L6694 – L6698, L7181

HCPCS Level II Codes with Description Changes

Durable Medical Equipment
E0450, E0461, E0625, E0951, E0952, E0953, E0955, E0956, E0957, E0967, E0978, E0986, E1010, E1011, E1014, E1038, E1225, E1226

Orthotic Procedures
L1820, L2035 – L2039, L2320, L2330, L2755, L2800, L4040, L4045, L4050, L4055

Prosthetic Procedures
L6890, L6895, L7180

CPT-4 Code Deletions

Acupuncture
97780, 97781

Please see **CPT-4/HCPCS**, *page 2*

CPT-4/HCPCS *(continued)*

HCPCS Level II Code Deletions

Durable Medical Equipment
E0454, E1012, E1013, K0059, K0060, K0061, K0081, K0627, K0650, K0668, S8182, S8183

Orthotic Procedures
L2435

Prosthetic Procedures
L5674, L5675, L5846, L5847, L5989, L8490

California Children's Services Billing Tips

The Department of Health Services and EDS continually monitor the claims payment process to identify and correct problems. This monitoring has identified several common billing errors that are causing California Children's Services (CCS) claims to be denied. Following are the most common billing errors along with billing tips to help prevent claim denials.

Billing Error	Billing Tip
A claim from a physician for inpatient services is billed using the Service Authorization Request (SAR) issued to the hospital.	Physicians must use the SAR issued for physician services. SARs issued to inpatient hospitals cover only the hospital days and are restricted to use by Inpatient providers.
The services on the claim do not match the services authorized on the SAR. (This error occurs most frequently with surgical procedures where additional services were also performed. In this case, submit a separate SAR for all surgical procedures with the specific requested procedure codes.)	The service billed must either be individually authorized on the SAR or contained within the Service Code Grouping (SCG) identified on the approved SAR. If the service billed is not authorized on the SAR submitted with the claim, the claim will be denied. The provider must submit an approved SAR.
The modifier on the claim used to bill for Durable Medial Equipment (DME) does not match the modifier on the SAR.	The modifier used to bill for the DME must match the modifier on the SAR. If after obtaining a SAR it is determined that an incorrect DME modifier was requested or authorized, the provider must obtain a new SAR. If the provider submits a claim with a modifier that does not match the modifier approved on the SAR (even if the modifier is appropriate), the claim will be denied.
The provider number submitted on the claim is not the provider number used to obtain the SAR.	A SAR number authorized to a physician may be used for reimbursement by other providers from whom the physician has requested services. In this case, the rendering provider will use the authorized physician's SAR number and bill with the authorized physician's Medi-Cal provider number indicated as a referring provider. **Note:** This does not apply to SARs issued to CCS Special Care Centers.

Please see **CCS Billing Tips**, *page 3*

CCS Billing Tips *(continued)*

Billing Error	Billing Tip
The CCS client's ID number on the claim does not match the client number indicated on the SAR.	With the exception of newborn babies using the mother's ID number for the month of birth or the following month, the ID number submitted on the claim must match the ID number indicated on the SAR. **Note:** Providers are reminded to verify the client's eligibility at each visit.
The number of units authorized on the SAR has been exhausted. These claims will most likely be denied for Remittance Advice Details (RAD) code 005, which indicates the service requires prior authorization.	Compare the number of units entered on the claim with the number of units previously submitted and approved on the SAR. Providers may also contact the Telephone Service Center (TSC) at 1-800-541-5555 (select Option 14, then Option 13 [Specialty Programs]), to verify available SAR units.
The dates billed are not within the dates authorized on the SAR. The claim will most likely be denied for RAD code 006, which indicates the dates billed are not within the authorized period.	Check the dates on the SAR. If they do not cover the time period for which you are billing, contact a CCS county or state regional office.

For additional information about proper SAR submission, refer to the *California Children's Services (CCS) Program Service Authorization Request (SAR)* section in the appropriate Part 2 manual.

Inpatient Provider Cut-off Date for Proprietary and Non-HIPAA Standard Electronic Claims Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal has established a plan to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claims transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005,** proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cut-off dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace: cal child sar 1/2

Remove: hcfa sub 1 thru 5
Insert: hcfa sub 1 thru 6 (new) *

* Pages updated due to ongoing provider manual revisions.